Dalton (H. C.)

Some recent surgical cases

SOME RECENT SURGICAL CASES.*

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CASE I.—STAB WOUND OF LIVER—LAPAROTOMY—RECOVERY.

William D., æt. 22, moulder, admitted April 24, 1890. He stated that an hour before admission he was stabbed in the abdomen with a long, narrow-bladed knife. Pulse was 92, respiration 26, temperature 99 ; no pain.

A small wound was noticed in the median line, an inch below the ensiform cartilage. The probe failed to show penetration. This, together with the general good condition of the patient, led us to believe that the abdomen had not been penetrated. The wound was dressed antiseptically, and patient put to bed.

A short while thereafter pain developed, and the temperature rose to 102.4; pulse 102. An incision was made from the ensiform cartilage to the umbilicus. When the cavity was opened a small wound, half an inch in length, was noticed on the upper surface of the left lobe of the liver. The finger passed underneath the liver discovered a large lacerated wound of the organ near the diaphragm, from which was coming an alarming hemorrhage. I endeavored to reach this point in order to suture the wound ; but in attempting this by elevating the liver and depressing the stomach, such fearful hemorrhage supervened as to render the procedure impossible. The hemorrhage was indeed so great that we all thought the patient would die upon the table. To tampon the region around the wound in the liver, in order to produce sufficient compression to stop the hemorrhage, was now all that was left us. This I did by stuffing in as much iodoform gauze as I could possibly get into this space.

* Reprint from THE ST. LOUIS COURIER OF MEDICINE, August, 1890.

I presume as much as a hatful of gauze was used. The end of each strip was left protruding from the wound. This procedure stopped the hemorrhage; but a considerable amount of blood was left in the peritoneal cavity. I deemed it wiser to allow it to remain rather than risk an attempt at its removal. The case was too urgent to admit of a periteneal toilet. The upper third of the wound was left open, the lower two-thirds closed by bow-knot silk sutures.

In a few hours the pulse and temperature fell almost to normal, and we flattered ourselves that the outlook was favorable; but in twenty-four hours the temperature rose to 103.6, the pulse to 120, and the respiration to 40. The patient was restless and in considerable pain.

He was etherized, wound opened and the dressing removed. I attempted to remove it layer by layer, in order to repack at once should the hemorrhage return. This I was unable to do on account of the matting together of the gauze, and the adhesion between it and the surrounding parts. A large amount of coagulated blood was removed from the cavity, particularly from the dorsal gutters. As soon as the gauze was removed, the hemorrhage became as great as, if not greater than, at the first dressing. The gauze was packed in as vigorously as in the first instance.

Patient did badly for some hours, was very restless, complained of great pain, and vomited quite often. His pulse was rapid and weak, but his temperature was not much elevated; about 101. At midnight, eight hours after the operation, his pulse was almost imperceptible. His cries for water were piteous. Believing that he would die in a few hours, I directed the nurse to give him all the water he wanted: this I had not done previously, because everything he had swallowed was ejected, also because the stomach was greatly compressed by the gauze; hence it was necessary to keep it as quiet as possible.

I was very much astonished, eight hours later, by finding the patient very much better. There was no pain, and the nausea and vomiting had almost ceased; temperature was 100.2; pulse 92; respiration 26. The gauze was removed forty-eight hours after the second packing. Its removal was not accompanied by

hemorrhage; a good many blood clots were removed; the peritoneal cavity thoroughly cleaned and closed.

The wound healed by granulation. He was discharged well, May 27, 1890, and is before you for examination.

Case II.—Abscess of Liver Following Dysentery.—Early Operation.—Recovery.

G. A. L., æt. 38, laborer, admitted March 19, 1890. About five weeks before admission he had quotidian intermittent fever. Prior to that time his health had been good. Five days before coming to the hospital acute diarrhœa developed, followed in a day or two by a severe case of dysentery, which was relieved after three or four days treatment.

On the 29th inst., (ten days after admission) I noticed that, although the dysentery had disappeared several days before, there was still fever; temperature ranging from 102 to 103. Percussion gave hepatic dullness inferiorly as low as an inch below the costal border, extending superiorly almost to the nipple. Deep pressure in the intercostal spaces, from the seventh to the ninth rib in the axillary line, gave slight tenderness. There were neither chilly sensations, nor sweating; in fact, nothing pointing to hepatic abscess, i. e., if we leave out of view a slight tenderness on deep pressure, and the general enlargement of the organ.

Suspecting, however, that we had to deal with an hepatic abscess in an early stage, I thought aspiration in order. The needle was passed between the eighth and ninth ribs in the axillary line, and pus was found about two inches and a half from the surface. The next day I resected two inches of the ninth rib, and after exposing the liver, stuffed enough gauze into the wound to keep it open well down to the liver; applied an antiseptic dressing and a firm bandage.

In forty-eight hours the dressing was removed and the liver found strongly adherent to the wound. The needle of the aspirator was passed, the abscess located, and an incision made by the side of the needle, evacuating about an ounce and a half of pus. The abscess was thoroughly irrigated with Thiersch solution. Patient made a rapid recovery and is now well and is present this evening.

The primary operation was done in order to shut off the pleural and peritoneal cavities so that no pus should pass into them at the time of the incision of the liver. Primary operation should always be done in early operations for hepatic abscess; for we may be sure inflammatory adhesion between the liver and thoracic wall, or the abdominal wall, has not had time to form. *Per contra* when we are certain adhesion has taken place—the operation may be completed at once. In fact, it then amounts to but little more than opening an ordinary abscess.

The lesson we learn from this case is the necessity of carefully watching the liver in all cases of dysentery and diarrhœa, boldly using the aspirating needle in case we are in doubt—giving the patient the benefit of the doubt. We may do this the more readily because we know how very rarely ill consequences follow aspiration of the liver, when we perform the operation strictly antiseptically. In order to make "assurance doubly sure" in this regard, we need but to thoroughly clean the needle, and then boil it for half an hour in a solution of two and a half per cent. carbolic acid.

CASE III.—GUNSHOT WOUND OF KIDNEY, LIVER AND LUNG—NON-INTERFERENCE—RECOVERY.

W. S., colored, æt. 25, laborer, admitted October 8, 1890. An hour before admission he received a gunshot wound of back, his assailant being twenty yards away. He was suffering intensely from shock and pain; pulse 135 and weak; temperature subnormal; respiration 30; extremities cold.

The bullet entered an inch to the right of the last dorsal vertebra, ranged upward and lodged under the skin on a level with, and an inch external to the right nipple. The urine was drawn and found quite bloody. The course of the bullet showed unmistakably that it had passed through the kidney, liver, and right lung. This was confirmed later by the development of jaundice and pneumonia; the latter developing on the second day. By the third day the entire lung was solidified; in addition to this there was absence of vocal fremitus over the lower portion of the lung, indicating extravasation of blood into the pleural cavity.

The urine became clear on the third day. For five days the

patient suffered intensely and looked as if he would die in a few hours. His pulse remained at about 140; respiration 50; temperature 103. After this he steadily improved and was discharged well, November 22, 1889.

I did not deem an operation advisable in this case. From the course of the bullet and the absence of liver resonance, I excluded injury of the intestine. Even had I found unmistakable evidence of intestinal perforation, I should not have operated at the time of his admission to the hospital, as I believe he would have died upon the table.

I watched the case closely, and stood ready to operate should occasion arise, i. e., should symptoms of septicæmia develop. I did not regard a temperature of 103 as at all excessive following an injury to so many important organs; and, as the temperature did not go higher, I excluded sepsis—and hence never saw the time when I thought an operation indicated.

Case IV.—Gunshot Wound of Liver and Kidney—Non-Interference—Recovery.

W. B., colored, æt. 24, laborer, admitted April 26, 1890. An hour before admission patient was shot by a 32-calibre revolver at a distance of four feet. He fell to the floor, and in a few minutes vomited, the ejecta being free from blood. His pulse was 100, and steady; respiration 23, temperature (rectal) 100, urine bloody.

The wound of entrance was on a level with, and two inches to the right of the ensiform cartilage. It was not probed. The bullet was found underneath the skin, two inches to the right of the eleventh dorsal vertebra. It was not disturbed. In its course it had penetrated the liver and right kidney.

The next morning the temperature was 102, respiration 18, pulse 78. From this time the patient recovered rapidly, and was discharged well, May 14, 1890.

Some of the gentlemen who saw the case with me thought an operation advisable; but I failed to see the necessity for it. There was resonance on percussion in the dorsal region, showing absence of hemorrhage from the injured organs. The liver dullness was normal (no increased resonance), indicating that the

intestines were uninjured, This condition led me to adopt the waiting course, ready to operate should occasion arise demanding it.

About two years ago I reported a case of shot wound of the liver in which the patient recovered without an operation. The bullet passed through the liver, through the diaphragm, into the pleural cavity and back again into the peritoneal cavity, lodging in the post-peritoneal space in the right lumbar region. An abscess formed at this side which was incised in a few days. Fæces passed out of the wound, showing that the gut had been cut by the bullet.

These cases teach us that, as a general thing, shot wounds of the liver and kidney are best let alone, unless grave symptoms be present indicating hemorrhage and rapidly developing peritonitis. Should such urgent symptoms be present, no one would question the advisability of an operation.